American Consulate General
Johannesburg, South Africa

INSTRUCTIONS REGARDING MEDICAL EXAMINATIONS FOR VISA APPLICANTS

Every visa applicant, *regardless of age*, is required to undergo a complete medical examination *prior* to the issuance of the immigrant visa. The completed medical forms, together with the serological and blood test results, must be submitted to the Consulate General on the appointed day. Please do NOT bring your x-ray plates with you as they are not necessary for the interview.

Applicants coming to South Africa from the United States for their final interviews

Applicants must arrange their travel itinerary so that they can undergo their medical examination *at least ten days prior* to their scheduled immigrant visa interview appointment. The reasons for this are that in case medical complications arise, further tests may be required. The test for Acquired Immune Deficiency Syndrome (***AIDS***) also takes approximately 3 days to complete in South Africa. The medical examination and the test for AIDS must be accomplished by one of our panel physicians in South Africa.

Kindly read carefully and follow the instructions below:

1. The attached Forms (DS-2053, DS-3024, DS-3025 & DS-3026), must be presented to the examining physician for completion.

2. Bring **two passport-sized photos** and **your passport** with you when appearing for the examination since, as indicated above, verification of your identity must be presented and the number of your passport photographed on to the X-Ray plate. One of your passport-sized photos must be affixed to Form DS-2053.

3. Kindly arrange to collect the completed Medical Reports and the X-Ray plate yourself. It will not be forwarded to you. The fee for the examination (approximately R750.00 for the medical examination, excluding vaccinations) must be borne by the applicant. Please note that the fees quoted are approximate and applicable only to South Africa.

4. Do not obtain any vaccinations prior to your medical examinations. You will pay an additional fee for each vaccine that you require. If you have any questions about required vaccines please contact one of the three listed panel physicians for advice on U.S. government requirements.

5. A TB skin test is required for all children aged 2-14 years (inclusive).

6. X-Rays and Serological tests are ***not*** required in cases of children under the age of fifteen years, ***unless*** the medical examiner has reason to suspect that such tests are necessary or if a child has as positive TB test.

7. If specifically requested by a pregnant immigrant visa applicant, a panel physician may waive the chest X-Ray examination requirement. The following statement should be typed or stamped on Form DS-3024 in the "Remarks" column: "Pregnant-X-Ray requirement waived at applicant's request."

(FOR YOUR INFORMATION: A Medical Examination Report is valid for a period of 12 months prior to the issuance of the visa unless you have what is termed a Class A condition)

THE FOLLOWING MEDICAL EXAMINERS HAVE BEEN APPROVED FOR THE MEDICAL EXAMINATION OF VISA APPLICANTS

JOHANNESBURG

Dr. Mark S. Singer
30 – 12th Avenue
Linksfield
2192 Johannesburg
011-485-1418/1439

Dr. Hugh Cobb
11 Sturdee Avenue
Rosebank
2196 Johannesburg
011-788-1344

DURBAN

Dr. John M. Blanckenberg
105 Jan Hofmeyr Road
Westville
Durban 3630
031-266-9258

CAPE TOWN

(Please note that at present there is no panel physician in Cape Town)

August 2008

U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

OMB No. 1405-0113
EXPIRATION DATE: 03/31/2011
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Photo

Name *(Last, First, MI.)* _____, _____, _____

Birth Date *(mm-dd-yyyy)* _____ **Sex:** ☐ M ☐ F

Birthplace *(City/Country)* _____ /_____

Present Country of Residence _____ **Prior Country** _____

U.S. Consul *(City/Country)* _____ /_____

Passport Number _____ **Alien** *(Case)* **Number** _____

Date *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

Date Exam Expires *(6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy)* _____

Exam Place *(City/Country)* _____ /_____ **Panel Physician** _____

Radiology Services _____ **Screening Site** *(name)* _____

Lab *(name for HIV/syphilis/TB)* _____ /_____ /_____

(1) Classification *(check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3024, DS-3025 and DS-3026)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Human immunodeficiency virus (HIV)
- ☐ Hansen's disease, lepromatous or multibacillary
- ☐ Addiction or abuse of specific* substance without harmful behavior
- ☐ Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, noninfectious *(Class B1, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ TB, inactive *(Class B2, from Chest X-Ray Worksheet)*
  Treatment: ☐ None ☐ Partial ☐ Completed
  See Section 4 on page 2 for TB treatment details
- ☐ Syphilis *(with residual deficit)*, treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Other *(specify or give details on checked conditions from worksheets)* _____
- ☐ Hansen's disease, prior treatment
- ☐ Hansen's disease, tuberculoid, borderline, or paucibacillary
- ☐ Sustained, full remission of addiction or abuse of specific* substances
- ☐ Any physical or mental disorder (excluding addiction or abuse of specific* substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

(2) Laboratory Findings *(check all boxes that apply):*

Syphilis: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Date(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*:E	

HIV: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Indeterminate	Notes
Screening			☐	☐	☐	
Secondary			☐	☐	☐	
Confirmatory			☐	☐	☐	

(3) Immunizations *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature	Panel Physician Signature	Date *(mm-dd-yyyy)*

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's weight (kg) _____

Remarks _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to U.S. Department of Homeland Security (DHS) for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).

U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053

OMB No. 1405-0113
EXPIRATION DATE: 03/31/2011
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairment in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiction or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease ☐ Tuberculoid ☐ Borderline ☐ Lepromatous *OR* ☐ Paucibacillary ☐ Multibacillary Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs)*, specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ / ____ *(mmHg)* Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status
☐	☐	☐	Hearing and ears
☐	☐	☐	Eyes
☐	☐	☐	Nose, mouth, and throat *(include dental)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*
☐	☐	☐	Breast
☐	☐	☐	Lungs
☐	☐	☐	Abdomen *(including liver, spleen)*
☐	☐	☐	Genitalia *(including circumcision, infection(s))*

N*	A*	ND*	
☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Lymph nodes
☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No	Yes	
☐	☐	Physical examination or laboratory results contradict medical history
☐	☐	Referral prior to departure If yes, provide results
☐	☐	Referral prior to departure If yes, provide results

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency

☐ For continuing other treatment, specify

5. Remarks *(describe any abnormal history, abnormal findings, and resulting interventions)*

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: the U.S. Department of State (A/ISS/DIR) Washington, DC 20520.

AUTHORITIES The information is sought pursuant to Sections 212(a), 221(d), 101, and 412(b)(4) and (5) of the Immigration and Nationality Act.

PURPOSE The primary purpose for soliciting medical information is to determine whether an applicant is eligible to obtain a visa and alien registration. This form is designed to record the result of the medical examination required by INA 221(d), which determines whether an applicant has a medical condition that renders the applicant ineligible under INA Section 212(a).

ROUTINE USES The information solicited on this form may be made available to the U.S. Department of Homeland Security for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. The information provided also may be released to federal agencies for law enforcement, counter-terrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies for certain personnel and records management matters.
Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

For Use with DS-2053 Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 03-31-2011
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name *(Last, First, MI.)*	Age

Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (Case) Number

1. Chest X-Ray *(Mark All that Apply)*

- ☐ History of Tuberculosis *(TB)* Disease
- ☐ Contact with Person with TB
- ☐ TB Signs or Symptoms
- ☐ Adult *(With or Without Any of the Other)*

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings

Date Chest X-Ray Taken *(mm-dd-yyyy)* _____

- ☐ Normal Findings
- ☐ Abnormal Findings *(Indicate findings and interpretation, by checking all that apply, and any other in the table below.)*

☐ **Can Suggest ACTIVE TB** *(Need Smears)*	☐ **Can Suggest INACTIVE TB** *(Need Smears if Symptomatic)*	☐ **OTHER X-Ray Findings**
☐ Infiltrate or Consolidation	☐ Discrete Fibrotic Scar or Linear Opacity	☐ **Follow-Up Needed**
☐ Any Cavitary Lesion	☐ Discrete Nodule*(s)* without Calcification	☐ Musculoskeletal
☐ Nodule with Poorly Defined Margins *(Such as Tuberculoma)*	☐ Discrete Fibrotic Scar with Volume Loss or Retraction	☐ Cardiac
☐ Pleural Effusion	☐ Discrete Nodule*(s)* with Volume Loss or Retraction	☐ Pulmonary
☐ Hilar/Mediastinal Adenopathy	☐ Other *(Such as Bronchiectasis)*	☐ Other
☐ Linear, Interstitial Markings		☐ **No Follow-Up Needed for** Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding
☐ Other *(Such as Miliary Findings)*		

Remarks

_____

_____

_____

3. Sputum Smears

☐ **No, Applicant has No Signs or Symptoms of TB and :**

- ☐ X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ OTHER X-Ray Findings Suggest N**o Follow-Up Needed,** this is **No Class**
- ☐ X-Ray Normal, this is **No Class**

☐ **Yes, Applicant has** *(Mark All that Apply)* :

- ☐ Signs or Symptoms of TB Present, See Section 1
- ☐ X-Ray Suggests ACTIVE TB, See Section 2

and Smear Results are:

Positive	Negative	Dates Obtained *(mm-dd-yyyy)*
☐	☐	_____
☐	☐	_____
☐	☐	_____

Sputum Smear Results and X-Ray

At least One Smear Result POSITIVE and

☐ Any Chest X-Ray Finding, this is **Class** *(Normal or Abnormal findings)*

Three Smear Results NEGATIVE and

☐ X-Ray Normal with

- ☐ Signs of Symptoms Resolved, this is **No Class**
- ☐ Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is **B Other**

☐ X-Ray Suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**

☐ OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is **Class B**

4. ☐ **No Class** ☐ **Class A/TB** ☐ **Class B1/TB** ☐ **Class B2/TB** ☐ **Class B Other, Follow-Up**

5. Follow-Up Needed After ☐ No ☐ Yes If Yes, for ☐ Not TB Condition ☐ TB Condition

(If yes, specify condition below ***and*** *on DS-2053; include additional tests, and therapy used with start and stop dates and any changes.)*

Remarks

_____

_____

_____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: the U.S. Department of State (A/ISS/DIR) Washington, DC 20520.

AUTHORITIES The information is sought pursuant to Sections 212(a), 221(d), 101, and 412(b)(4) and (5) of the Immigration and Nationality Act.

PURPOSE The primary purpose for soliciting medical information is to determine whether an applicant is eligible to obtain a visa and alien registration. This form is designed to record the result of the medical examination required by INA 221(d), which determines whether an applicant has a medical condition that renders the applicant ineligible under INA Section 212(a).

ROUTINE USES The information solicited on this form may be made available to the U.S. Department of Homeland Security for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. The information provided also may be released to federal agencies for law enforcement, counter-terrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies for certain personnel and records management matters.

Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 — To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 03/31/2011
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

Name *(Last, First, MI.)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (*Case*) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available.

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(List Chronologically from Left to Right)* — Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series (✓ *if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below — Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall *(Flu)* Season
Specify (*check*) vaccine: ☐ DT ☐ DTP ☐ DTaP											
Specify (*check*) vaccine: ☐ Td ☐ Tdap											
Specify (*check*) vaccine: ☐ Polio -OPV ☐ IPV											
Specify (*check*) vaccine: ☐ MMR (Measles-Mumps-Rubella) ☐ Rubella											
Specify (*check*) vaccine: ☐ Measles ☐ Measles - Rubella											
Specify (*check*) vaccine: ☐ Mumps ☐ Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Hepatitis B											
Meningococcal											
Human papillomavirus											
Varicella											
Zoster											
Pneumococcal											
Influenza											

2. Results

☐ Vaccine History Incomplete

☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as Indicated Above)*.

☐ Applicant will request an individual waiver based on religious or moral convictions.

☐ Vaccine history complete for each vaccine, all requirements met *(Documented Above)*.

☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(Name)* _____

Panel Physician *(Signature)* _____

Date *(mm-dd-yyyy)* _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of burden and recommendations for reducing it to: Department of State (A/ISS/DIR) Washington, DC 20520-1849.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Section 212 (a) and 221 (d), and as required by INA Section 212(g)(2). If an immigrant visa is issued, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued, this form will be treated as confidential under INA Section 222(f).

U.S. Department of State

APPLICATION FOR IMMIGRANT VISA AND ALIEN REGISTRATION

OMB APPROVAL NO. 1405-0015
EXPIRES: 05/31/2011
ESTIMATED BURDEN: 1 HOUR*
(See Page 2)

PART I - BIOGRAPHIC DATA

Instructions: Complete one copy of this form for yourself and each member of your family, regardless of age, who will immigrate with you. Please print or type your answers to all questions. Mark questions that are **Not Applicable** with **"N/A"**. If there is insufficient room on the form, answer on a separate sheet using the same numbers that appear on the form. **Attach any additional sheets to this form.**

Warning: Any false statement or concealment of a material fact may result in your permanent exclusion from the United States.
This form *(DS-230 Part I)* is the first of two parts. This part, together with Form DS-230 Part II, constitutes the complete Application for Immigrant Visa and Alien Registration.

1. Family Name | First Name | Middle Name

2. Other Names Used or Aliases *(If married woman, give maiden name)*

3. Full Name in Native Alphabet *(If Roman letters not used)*

4. Date of Birth *(mm-dd-yyyy)*	5. Age	6. Place of Birth *(City or town)*	*(Province)*	*(Country)*

7. Nationality *(If dual national, give both)*

8. Gender ☐ Female ☐ Male

9. Marital Status ☐ Single *(Never married)* ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Including my present marriage, I have been married _____ times.

10. Permanent address in the United States where you intend to live, if known *(street address including ZIP code)*. Include the name of a person who currently lives there.

Telephone number

11. Address in the United States where you want your Permanent Resident Card *(Green Card)* mailed, if different from address in item #10 *(include the name of a person who currently lives there)*.

Telephone number

12. Your Present Occupation

13. Present Address *(Street Address) (City or Town) (Province) (Country)*

Telephone Number *(Home)* | Office

14. Name of Spouse *(Maiden or family name)* | First Name | Middle Name

Date *(mm-dd-yyyy)* and Place of Birth of Spouse

Address of Spouse *(If different from your own)*

Spouse's Occupation

Date of Marriage *(mm-dd-yyyy)*

15. Father's Family Name | First Name | Middle Name

16. Father's Date of Birth *(mm-dd-yyyy)*	Place of Birth	Current Address	If Deceased, Give Year of Death

17. Mother's Family Name at Birth | First Name | Middle Name

18. Mother's Date of Birth *(mm-dd-yyyy)*	Place of Birth	Current Address	If Deceased, Give Year of Death

19. List Names, Dates and Places of Birth, and Addresses of **ALL** Children.

NAME	DATE *(mm-dd-yyyy)*	PLACE OF BIRTH	ADDRESS *(If different from your own)*

20. List below all places you have lived for at least six months since reaching the age of 16, including places in your country of nationality. Begin with your present residence.

CITY OR TOWN	PROVINCE	COUNTRY	FROM/TO *(mm-yyyy)*

21a. Person(s) named in 14 and 19 who will accompany you to the United States now.

21b. Person(s) named in 14 and 19 who will follow you to the United States at a later date.

22. List below all employment for the last ten years.

EMPLOYER	LOCATION	JOB TITLE	FROM/TO *(mm-yyyy)*	

In what occupation do you intend to work in the United States? _____

23. List below all educational institutions attended.

SCHOOL AND LOCATION	FROM/TO *(mm-yyyy)*		COURSE OF STUDY	DEGREE OR DIPLOMA

Languages spoken or read: _____

Professional associations to which you belong: _____

24. Previous Military Service ☐ Yes ☐ No

Branch: _____ Dates *(mm-dd-yyyy)* of Service: _____

Rank/Position: _____ Military Speciality/Occupation: _____

25. List dates of all previous visits to or residence in the United States. *(If never, write "never")* Give type of visa status, if known. Give DHS "A" number if any.

FROM/TO *(mm-yyyy)*		LOCATION	TYPE OF VISA	"A" NO. *(If known)*

SIGNATURE OF APPLICANT	DATE *(mm-dd-yyyy)*

Privacy Act and Paperwork Reduction Act Statements

The information asked for on this form is requested pursuant to Section 222 of the Immigration and Nationality Act. The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue you a social security number and card.

*Public reporting burden for this collection of information is estimated to average 1 hour per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. In accordance with 5 CFR 1320 5(b), persons are not required to respond to the collection of this information unless this form displays a currently valid OMB control number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/ISS/DIR) Washington, DC 20520.

U.S. Department of State

APPLICATION FOR IMMIGRANT VISA AND ALIEN REGISTRATION

OMB APPROVAL NO. 1405-0015
EXPIRES: 05/31/2011
ESTIMATED BURDEN: 1 HOUR*

PART II - SWORN STATEMENT

INSTRUCTIONS: Complete one copy of this form for yourself and each member of your family, regardless of age, who will immigrate with you. Please print or type your answers to all questions. Mark questions that are **Not Applicable** with **"N/A"**. If there is insufficient room on the form, answer on a separate sheet using the same numbers that appear on the form. Attach any additional sheets to this form. The fee should be paid in United States dollars or local currency equivalent, or by bank draft.

WARNING: Any false statement or concealment of a material fact may result in your permanent exclusion from the United States. Even if you are issued an immigrant visa and are subsequently admitted to the United States, providing false information on this form could be grounds for your prosecution and/or deportation.

This form (DS-230 PART II), together with Form DS-230 PART I, constitutes the complete Application for Immigrant Visa and Alien Registration.

26. Family Name | First Name | Middle Name

27. Other Names Used or Aliases *(If married woman, give maiden name)*

28. Full Name in Native Alphabet *(If Roman letters not used)*

29. Name and Address of Petitioner

Telephone number:

30. United States laws governing the issuance of visas require each applicant to state whether or not he or she is a member of any class of individuals excluded from admission into the United States. The excludable classes are described below in general terms. You should read carefully the following list and answer YES or NO to each category. The answers you give will assist the consular officer to reach a decision on your eligibility to receive a visa.

EXCEPT AS OTHERWISE PROVIDED BY LAW, ALIENS WITHIN THE FOLLOWING CLASSIFICATIONS ARE INELIGIBLE TO RECEIVE A VISA.

DO ANY OF THE FOLLOWING CLASSES APPLY TO YOU?

a. An alien who has a communicable disease of public health significance; who has failed to present documentation of having received vaccinations in accordance with U.S. law; who has or has had a physical or mental disorder that poses or is likely to pose a threat to the safety or welfare of the alien or others; or who is a drug abuser or addict. ☐ Yes ☐ No

b. An alien convicted of, or who admits having committed, a crime involving moral turpitude or violation of any law relating to a controlled substance or who is the spouse, son or daughter of such a trafficker who knowingly has benefited from the trafficking activities in the past five years; who has been convicted of 2 or more offenses for which the aggregate sentences were 5 years or more; who is coming to the United States to engage in prostitution or commercialized vice or who has engaged in prostitution or procuring within the past 10 years; who is or has been an illicit trafficker in any controlled substance; who has committed a serious criminal offense in the United States and who has asserted immunity from prosecution; who, while serving as a foreign government official, was responsible for or directly carried out particularly severe violations of religious freedom; or whom the President has identified as a person who plays a significant role in a severe form of trafficking in persons, who otherwise has knowingly aided, abetted, assisted or colluded with such a trafficker in severe forms of trafficking in persons, or who is the spouse, son or daughter of such a trafficker who knowingly has benefited from the trafficking activities within the past five years. ☐ Yes ☐ No

c. An alien who seeks to enter the United States to engage in espionage, sabotage, export control violations, terrorist activities, the overthrow of the Government of the United States or other unlawful activity; who is a member of or affiliated with the Communist or other totalitarian party; who participated, engaged or ordered genocide, torture, or extrajudicial killings; or who is a member or representative of a terrorist organization as currently designated by the U.S. Secretary of State. ☐ Yes ☐ No

d. An alien who is likely to become a public charge. ☐ Yes ☐ No

e. An alien who seeks to enter for the purpose of performing skilled or unskilled labor who has not been certified by the Secretary of Labor; who is a graduate of a foreign medical school seeking to perform medical services who has not passed the NBME exam or its equivalent; or who is a health care worker seeking to perform such work without a certificate from the CGFNS or from an equivalent approved independent credentialing organization. ☐ Yes ☐ No

f. An alien who failed to attend a hearing on deportation or inadmissibility within the last 5 years; who seeks or has sought a visa, entry into the United States, or any immigration benefit by fraud or misrepresentation; who knowingly assisted any other alien to enter or try to enter the United States in violation of law; who, after November 30, 1996, attended in student (F) visa status a U.S. public elementary school or who attended a U.S. public secondary school without reimbursing the school; or who is subject to a civil penalty under INA 274C. ☐ Yes ☐ No

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g. An alien who is permanently ineligible for U.S. citizenship; or who departed the United States to evade military service in time of war. ☐ Yes ☐ No

h. An alien who was previously ordered removed within the last 5 years or ordered removed a second time within the last 20 years; who was previously unlawfully present and ordered removed within the last 10 years or ordered removed a second time within the last 20 years; who was convicted of an aggravated felony and ordered removed; who was previously unlawfully present in the United States for more than 180 days but less than one year who voluntarily departed within the last 3 years; or who was unlawfully present for more than one year or an aggregate of one year within the last 10 years. ☐ Yes ☐ No

i. An alien who is coming to the United States to practice polygamy; who withholds custody of a U.S. citizen child outside the United States from a person granted legal custody by a U.S. court or intentionally assists another person to do so; who has voted in the United States in violation of any law or regulation; or who renounced U.S. citizenship to avoid taxation. ☐ Yes ☐ No

j. An alien who is a former exchange visitor who has not fulfilled the 2-year foreign residence requirement. ☐ Yes ☐ No

k. An alien determined by the Attorney General to have knowingly made a frivolous application for asylum. ☐ Yes ☐ No

l. An alien who has ordered, carried out or materially assisted in extrajudicial and political killings and other acts of violence against the Haitian people; who has directly or indirectly assisted or supported any of the groups in Colombia known as FARC, ELN, or AUC; who through abuse of a governmental or political position has converted for personal gain, confiscated or expropriated property in Cuba, a claim to which is owned by a national of the United States, has trafficked in such property or has been complicit in such conversion, has committed similar acts in another country, or is the spouse, minor child or agent of an alien who has committed such acts; who has been directly involved in the establishment or enforcement of population controls forcing a woman to undergo an abortion against her free choice or a man or a woman to undergo sterilization against his or her free choice; or who has disclosed or trafficked in confidential U.S. business information obtained in connection with U.S. participation in the Chemical Weapons Convention or is the spouse, minor child or agent of such a person. ☐ Yes ☐ No

31. Have you ever been charged, arrested or convicted of any offense or crime? ☐ Yes ☐ No
(If answer is Yes, please explain)

32. Have you ever been refused admission to the United States at a port-of-entry? ☐ Yes ☐ No
(If answer is Yes, please explain)

33a. Have you ever applied for a Social Security Number (SSN)?

☐ Yes Give the number _____ ☐ No

Do you want the Social Security Administration to assign you an SSN (and issue a card) or issue you a new card (if you have an SSN)? You must answer "Yes" to this question and to the "Consent To Disclosure" in order to receive an SSN and/or card.

☐ Yes ☐ No

33b. **CONSENT TO DISCLOSURE:** I authorize disclosure of information from this form to the Department of Homeland Security (DHS), the Social Security Administration (SSA), such other U.S. Government agencies as may be required for the purpose of assigning me an SSN and issuing me a Social Security card, and I authorize the SSA to share my SSN with the INS.

☐ Yes ☐ No

The applicant's response does not limit or restrict the Government's ability to obtain his or her SSN, or other information on this form, for enforcement or other purposes as authorized by law.

34. WERE YOU ASSISTED IN COMPLETING THIS APPLICATION? ☐ Yes ☐ No

(If answer is Yes, give name and address of person assisting you, indicating whether relative, friend, travel agent, attorney, or other)

DO NOT WRITE BELOW THE FOLLOWING LINE
The consular officer will assist you in answering item 35.
DO NOT SIGN this form until instructed to do so by the consular officer

35. I claim to be:

☐ A Family-Sponsored Immigrant
☐ An Employment-Based Immigrant
☐ A Diversity Immigrant
☐ A Special Category *(Specify)* _____
(Returning resident, Hong Kong, Tibetan, Private Legislation, etc.)

☐ I derive foreign state chargeability under Sec. 202(b) through my _____

☐ Preference: _____

☐ Numerical limitation: _____
(foreign state)

I understand that I am required to surrender my visa to the United States Immigration Officer at the place where I apply to enter the United States, and that the possession of a visa does not entitle me to enter the United States if at that time I am found to be inadmissible under the immigration laws.

I understand that any willfully false or misleading statement or willful concealment of a material fact made by me herein may subject me to permanent exclusion from the United States and, if I am admitted to the United States, may subject me to criminal prosecution and/or deportation.

I, the undersigned applicant for a United States immigrant visa, do solemnly swear (or affirm) that all statements which appear in this application, consisting of Form DS-230 Part I and Part II combined, have been made by me, including the answers to items 1 through 35 inclusive, and that they are true and complete to the best of my knowledge and belief. I do further swear (or affirm) that, if admitted into the United States, I will not engage in activities which would be prejudical to the public interest, or endanger the welfare, safety, or security of the United States; in activities which would be prohibited by the laws of the United States relating to espionage, sabotage, public disorder, or in other activities subversive to the national security; in any activity a purpose of which is the opposition to or the control, or overthrow of, the Government of the United States, by force, violence, or other unconstitutional means.

I understand that completion of this form by persons required by law to register with the Selective Service System (males 18 through 25 years of age) constitutes such registration in accordance with the Military Selective Service Act.

I understand all the foregoing statements, having asked for and obtained an explanation on every point which was not clear to me.

_____
Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ _____ at: _____

_____
Consular Officer